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Testimony Of Wayne E. Stanfield
President and CEO of the
National Association of Independent Medical Equipment Suppliers (NAIMES)
On behalf of its Members

Before the House Small Business Sub-Committee
On Rural and Urban Entrepreneurship

February 11, 2009 at 10:00 am

Summary Statement

Chairman Shuler, Ranking Member Luetkemeyer, members of the Committee, my name is Wayne Stanfield and I am President and CEO of the National Association of Independent Medical Equipment Suppliers (NAIMES). We are a trade association representing and supporting the independent durable medical equipment (DME) supplier community. I am also a partner in an independent DME supplier, Carolina Med-Plus, Inc that is in the Round One Charlotte, NC CBA. We participated in the bid process last year but did not win a contract because we were above the pivotal bid.

NAIMES commends this Subcommittee for examining the impact of CMS's competitive bidding program for DME on small suppliers, which will be profound. Competitive bidding for DME was a part of the Medicare Modernization Act of 2003 and while the stated purpose was to save Medicare money, that contention gave no consideration to the service to patients, and the impact on small businesses, communities, and employment. CMS contends that DME competitive bidding represents a "market-based efficiency." I respectfully submit that this program does not represent anything close to healthy market economics.

Competitive bidding makes perfect sense for a multi-million dollar aerial tanker replacement for the Air Force, but makes no sense at all for an $89 walker or life sustaining oxygen services for a senior citizen. Competitive bidding has no place in healthcare and will result in higher costs to Medicare, lower quality products and less access to needed services by Medicare beneficiaries.

Competitive bidding is an exclusionary process. It is important to understand the gravity of this assault on small business in America. Since the vast majority of HME providers are small and independently owned, it stands to reason that they will bear the brunt of the burden.

According to CMS figures from 2007, there are 110,272 supplier numbers billing Medicare and of those 103,227 bill Medicare less than $300,000 per year. That is 94% of the total suppliers. It is also important to note that despite new start-up businesses in the DME industry, there was a decrease of more than 4,000 suppliers from 2006 to 2007. Also notable is that in the cancelled first round, winning bids in the 10 bid areas represented less than 10% of the total supplier numbers active in those localities, meaning 90% of the suppliers were excluded from the Medicare marketplace in their own communities.

These small businesses are a major part of the engine of the American free enterprise system. They employ more than 1.5 million people while serving over 50 million Medicare, Medicaid, and private insurance patients each year. These businesses help keep patients out of institutional settings and at home where not only do they prefer to be, but is the least costly alternative for everyone.

The DME segment of Medicare is historically less than 2% of the total Medicare budget and in spite of the growth in the Medicare population, has been virtually flat in growth of expenditures decades. Yet, this smallest segment of Medicare expenditures is repeatedly singled out for fee cuts, competitive bidding, and other measures such as surety bonds, all of which are forcing businesses to close or stop serving Medicare patients. Homecare and DME should be growing since the cost of this care is infinitely less expensive than a hospital or nursing home. According to a recent market study by the Freedonia Group, the need for medical equipment will grow by about 5.5% through 2012, primarily due to the rising number of older Americans. A program that reduces suppliers at a time when demand is increasing simply defies logic.

It has been acknowledged by CMS and industry experts that the competitive bidding process, when complete, will eliminate up to 90% of these businesses from the Medicare provider rolls. Should this happen, it will be devastating to this supplier community, as well as severely limiting access to medical equipment for Medicare beneficiaries. The remaining suppliers will not be able to meet the demand created by the growing Medicare population. As the baby boomers age, every day an average of 7,918 people will be added to the Medicare roles. For the DME industry this means a growing market. Under a free-market economic theory, this will mean that more competitors will be entering this market, helping to drive down or stabilize prices in the face of increasing demand. Competitive bidding will have the opposite effect.

This government-sponsored program will eliminate competition by dismantling a national network of suppliers that have reliably serviced the home health needs of Medicare patients for decades. While CMS has developed this program and has released the final rules for its re-implementation, it is Congress that authorized CMS to pursue this unworkable program. It is inconceivable that it would be our government that would promote a scheme to concentrate market share and eliminate competition at such a crucial time for our economy. This is a formula for higher prices over time and is bad public policy that must be ended now.

NAIMES strongly opposes the re-implementation of this flawed program and recommends that Congress repeal the applicable portions of the Medicare Modernization Act of 2003 as soon as possible. Much of the anticipated savings have already been realized through previously instituted reimbursement cuts, such as the FEHBP cuts in 2007, the elimination of

CPI increases for DME services for more than 5 years, and the devastating 9.5% cut on fees for bid products effective at the beginning of 2009.

I urge this Subcommittee to support the repeal of competitive bidding and return the free enterprise system to the small independently owned DME providers and allow them to meet the needs of America's aging population.

Thank you Chairman Shuler for this opportunity to testify before this Committee today.

Additional comments in conjunction with my testimony at the hearing held by the House Small Business Sub-Committee on Rural and Urban Entrepreneurship on February 11, 2009

The **National Association of Independent Medical Equipment Suppliers (NAIMES)** strongly urges Congress to immediately suspend the pending restart of Round One of the Medicare competitive bidding program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), and ultimately repeal the provisions of the Medicare Modernization Act of 2003 (MMA03) establishing this program.

This flawed program is bad public policy and will neither save money for Medicare, nor achieve its goal to reduce DMEPOS fraud and abuse. A program of patient care based on the lowest bid will create a two-tiered system for DMEPOS and restrict patient access to care. The statute also unconstitutionally eliminates due process for participating suppliers by waiving federal acquisition regulations and removes all administrative and judicial review.

In July 2005, despite the outcry from Congress and the public, the Centers for Medicare and Medicaid Services (CMS) began implementing the program in the first 10 of 80 areas of the country in July 2008. Although ultimately delayed at a tremendous cost to providers, CMS is now set to restart the program without making substantial changes to the rules. Reports clearly showed that there were serious problems with the program during the 15 days it was in effect.

Although Congress made changes with the passage of the Medicare Improvements and Patient Protection Act of 2008 (MIPPA) designed to address some of the concerns raised by the supplier community, fundamentally the program remains intact and still has most of the same concerns. With the procedural flaws, operational problems and other irregularities that have repeatedly been brought to the attention of CMS, it is clear that there are serious problems in the manner in which competitive bidding is being implemented and the fairness of the overall process. The same problems of transparency and inadequate procedural controls exists as CMS now restarts the program without significant changes. Congress must now exercise proper oversight and repeal competitive bidding before grievous harm is caused to millions of beneficiaries and tens of thousands of small businesses. It is clear that the intent of Congress will not be met by this program; and it threatens the financial viability of a large number of qualified and accredited DME suppliers as well as the future of the entire homecare industry.

One of the most critical issues with competitive bidding is the apathetic lack of understanding of how the DME industry connets with other healthcare providers and functions. The DME supplier community is made up of providers who serve a local service area, sometimes as small as few miles in any area. In most cases, these service areas are literally a community, particularly in large metropolitan areas. The bidding process of requiring a bid winner to serve the entire competitive bidding area (CBA) is in itself exclusionary. An accredited provider serving the western most part of the Riverside, California CBA would find it physically impossible to serve the easternmost area 120 miles away. Expecting that same supplier to subcontract in order to stay in business would require business expertise far beyond the abilities of most small businesses.

Another serious problem with the bidding program occurred with the start of round one in July of 2008. Referral sources were unable to find suppliers who could provide equipment to their patients. Sometimes a physician's staff would have to call 4 or 5 suppliers to get the same services they were ordering before for a local supplier they knew and trusted to care for their patients. Often when a supplier was located, there was a delay of several days to obtain equipment due to either the distance the contracted supplier had to travel, or the equipment would be shipped by UPS to the patient. This caused additional cost to the Medicare program in many cases because a patient was not able to be discharged because equipment was not available.

Suppliers who were not selected for a contract were contacted by a bid winner who did not have a presence in the local area and offered a contract. In numerous cases, the non-contract supplier was told that they would be paid 80% of the contract fee to handle all aspect of the service except billing. In most of those cases, the bid winner told the subcontractor they would not be paid until after the bid winner was paid. There were cases where an oxygen provider with one location in one CBA won a contract for 8 of the 10 CBAs with no ability to serve the areas thousands of miles away.

In all of the CBAs, there were bid winners in equipment categories where the winner had no experience, and no qualified staff to perform the service. Often these bid winners bid low expecting to win with the sole purpose of making "a fortune" by finding subcontractors to do the work. They were then left unable to serve the patient's needs because the fees were too low for any subcontractor to accept the patient. In one case a pharmacy won a bid for power wheelchairs and has never provided power mobility before.

Other suppliers bid to win with the intent to seek a buyer for their company if they were awarded a contract, despite CMS rules that placed restrictions on such transfers of ownership.

It is clear that this entire program is flawed and if implemented would result in serious harm to small suppliers and create a situation where the needs of the Medicare beneficiaries would not be met. All of the studies related to the competitive bidding program, including the independent Drexel study published in 2007, supports the industry's view that competitive bidding as designed would not function as CMS expected and would be anti-competitive. The Robert Morris University study and the Drexel study show clearly that this program is in fact not competitive bidding at all.

Statement from the Drexel Study conclusion:

> The problem with the CMS process is that the bid scoring and price formulation procedures are inconsistent with the bidding behavior that CMS wishes to induce. That is, overly complex rules for choosing winners and setting prices distort the incentives that bidders face and may actually result in increased prices for some consumers. We believe that the misalignment of the rules with the desired bidding behavior stems from a faulty application of single-unit auction results to a multi-unit setting: a misconception that has even been propagated by Nobel Laureates (see Ausubel and Cramton 2002, pp. 1, 27, for a discussion).

Conclusion from Robert Morris Study:

> In short, the proposed competitive bidding for medical equipment and supplies will increase concentration and will reduce competition. Medicare already regulates price and, if price is truly too high, could reduce it. This leaves us to ask, what will we gain from competitive bidding? Administrative convenience or capture, appear to be the only justifiable reasons. There may be a short run advantage to CMS if successful bidders are willing to cut price (or pay a premium) to gain market power, and it may be easier to regulate fewer firms. However, in the long run the bidding scheme will have traded a competitive market for government-

mandated concentrated market. As a result, we will have traded small short run benefits for major long run problems – poor public policy indeed.

It should also be noted that CMS has ample authority to adjust prices to meet market demands without implementing such a program. The concept of this misguided program came about because the creators did not understand the DME industry and how the network of over 100,000 suppliers has been woven into the fabric of healthcare in virtually every community. The businesses, small and large, live and work in neighborhoods where it is literally, "neighbors serving neighbors". It is not possible to move away from that concept without harming everyone involved, including the patient, the physician, and every other component of healthcare that touches that patient.

The following problems and concerns with the original start of Round One have been identified by NAIMES.

1. Hundreds of suppliers were improperly disqualified based on errors and unsubstantiated reasons, indicating mistakes and flaws in how CMS managed the selection process.

2. CMS changed the program rules without notifying bidders. There is no indication that the revised implementation rules are any more transparent.

3. Based on CMS figures, more than 1000 suppliers were excluded from the original start in Round One areas. There were approximately 300 bid winning companies to serve all beneficiaries in the bid categories in the first 10 competitive bid areas (CBA). There is no indication in the newly released final rule that changes this outcome.

4. Suppliers who had no presence in a geographical region were awarded contracts. Suppliers were offered contracts to serve all regions without having any viable plan to do so and without any subcontracts with other suppliers to serve bid areas for them. CMS used no mechanism to verify a supplier's ability to meet the bid criteria. Despite the mandate in HR 6331, the new final rule does not clearly rule out this happening again.

5. Suppliers were offered contracts to provide product categories that they have never provided before. CMS did not verify that a supplier was experienced in a product category even though there was claims history available from the DME Medicare carriers.

6. The bid process and criteria used by CMS allowed suppliers to submit a bid without proving their ability to perform under the contract. Most of the information submitted was subjective without any appropriate means for CMS to verify its accuracy.

7. The online bidding software program was fraught with problems and errors as well as being so un-user friendly that undetected errors could be made. Despite claims that this has been resolved, there has be no details provided to prove it.

8. Bid prices were extremely low, resulting in a low median price. Many suppliers bid purely to insure they would be included rather than understanding that such unsustainable low bids would harm all bid winners.

9. Due to the elimination of due process in the statute, and the subsequent shroud of secrecy, CMS refused to share meaningful data to allow a third party to assess the likely impact of the program on suppliers and beneficiaries. This is in stark contrast to customary standards of government

transparency. The new final rule does little to change this problem and due process can only be restored by Congressional action.

10. The flawed bidding process set a pivotal bid based on capacity that was not validated by CMS. This resulted in only the lowest bidder's prices being included in the final median fee calculation. This set the new fee schedule lower than suppliers can operate and still remain financially sound. All of the studies related to this program noted that this process of setting the bid amount was seriously flawed.

11. The contract offered by CMS allowed no recourse for a supplier that accepts the bid offer and then finds they are unable to meet the terms of the contract. The only way out of the contract is for CMS to terminate it for breach of contract. This indicates the only escape for a supplier is to go out of business.

12. Contract language indicated that breach of contract can result in the loss of the bidder's supplier number. Failure to meet the bid criteria would eliminate a supplier from the Medicare program completely, even though they can still supply non-bid products in the area. This is an uncommon and counterproductive business practice in any marketplace and unjustly penalizes a supplier who accepts the contact without knowing the consequences.

13. Winning suppliers have no guarantee of any new business since larger companies could capture market share by using their substantial resources to promote their businesses.

14. Physicians contacted by NAIMES have grave concerns about their patients under this program. With their usual list of preferred suppliers reduced by as much as 90%, many are concerned for the well-being of their patients after implementation. In the original start of Round One in July 2008, CMS failed to adequately notify hospitals, physicians, and other healthcare professionals about the changes.

15. CMS failed to provide adequate notice or information to those being affected. By the time bid winners were formally announced, there was less than 60 days to complete the requisite community education of this untried, unproven program filled with many unintended consequences.

16. The Program Advisory and Oversight Committee (PAOC) was created as a part of the bidding program. The purpose of this committee was to advise CMS on issues and concerns in order to make the program better. Despite the many concerns raised as the program was developed, few of the recommendation of the PAOC were used by CMS. Virtually all of the problems that came to light after the bidding process was launched were addressed by the PAOC committee.

NAIMES is very concerned about competitive bidding and will work with members of Congress to help meet the stated goals for this program following repeal. NAIMES can offer alternatives that will both reduce fraud and abuse, and reduce program costs by applying realistic solutions.

NAIMES cannot emphasize strongly enough the importance of STOPPING this program and urges Congress to immediately suspend re-implementation while working to repeal these provisions this flawed program.